

Informed Consent for Ketamine Assisted Psychotherapy

By signing this form, I acknowledge and agree to the following:

1. I have received and reviewed the KAP Information sheet, as well as the KAP Practice Policies document.
2. I have had the opportunity to question one of the persons involved in my ketamine therapy and have received satisfactory answers.
3. I understand that I am to have nothing in my stomach after midnight the night before my ketamine dosing session, except for my usual medications taken with sips of water.
4. I understand that I need to have someone drive me home from the treatments, and to not engage in any driving or operation of machinery on the day of the ketamine dosing session.
5. I fully understand that the ketamine sessions can result in a profound change in mental state and may result in unusual psychological and physiological effects.
6. I have been given a signed copy of this informed consent form, which is mine to keep.
7. I understand the risks and benefits of ketamine therapy, and I freely give my consent to participate in ketamine therapy outlined in the KAP Information sheet, under the conditions outlined.
8. I understand that I may withdraw from ketamine therapy at any time up until the actual injection or lozenge has been given.
9. I understand all information stated in the KAP Practice Policies document regarding confidentiality, payment, cancellations, professional records, and complaints, and agree to abide by its terms during our professional relationship.

Client

Name

Signature

Date

Medical Doctor

Robert M Grant, MD

Name

Signature

Date

Psychotherapist/psychologist

Jessica Katzman, PsyD

Name

Signature

Date